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Health and Well-Being

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Health is both a cause and constituent of well-being. A stronger view, which I shall contest, is that health is simply one kind of well-being and that the value of health consists of its contribution to well-being. Section 1 briefly defends the view that health is both a cause and constituent of well-being and distinguishes that view from the stronger claim that health is a kind of well-being. Section 2 considers whether contributing to well-being or possessing some other evaluative property is essential to health. Section 3 explores further implications of the view that the value of health consists in its contribution to well-being and lays out arguments in its defense. Section 4 criticizes those arguments, and section 5 points out contrasts between health and well-being. Throughout this chapter, I shall attempt to bring my abstract claims down to earth by linking them to a particular health state: deafness.

1. Health as a Cause and Constituent or as a Species of Well-Being

There is, to say the least, no consensus among philosophers concerning what constitutes well-being—that is, living a good life. So there is no feasible way to show that aspects of health and its consequences meet the established criteria for promoting well-being. Yet there is a broad consensus among both philosophers and non-philosophers concerning many of the typical constituents of well-being. That greater health typically promotes well-being and that some ways of being healthier are themselves ways of being better off are part of that consensus. But merely to point to this fact is not much of an argument against someone who disagrees. Fortunately, other platitudes concerning well-being reinforce the connection between health and well-being. For example, even those who reject hedonism usually agree that alleviating pain, nausea, or vertigo makes people better off (other things being equal), and lessening these conditions is, of course, a health improvement. Most people agree that succeeding in worthwhile projects—from child-rearing to treaty-making—enhances well-being, and better mental and physical functioning promote these successes. Without further belaboring of the obvious, we can take it as established that better health typically promotes well-being and that, in some cases at least, health improvements constitute improvements in well-being.

A more controversial view maintains that health is a kind of well-being. One expression of that view can be found in the definition of health given by the World Health Organization in 1947 as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (1948, p. 100). If health is identical to a state of well-being, then it is a necessary, rather than a contingent, truth that health promotes well-being. Most of those who hold such a view have taken the necessity to be conceptual. They have taken health, like well-being, to be an evaluative notion. If they are right and an increase in well-being is entailed by an improvement in health, then if Jack is healthier than Jill and their non-health
circumstances are identical, it must necessarily be the case that Jack is better off than Jill. On this view, comparisons of health are not purely naturalistic inquiries into bodily and mental functioning.

Even if it is a conceptual truth that health promotes well-being, it has other properties and consequences beyond its contribution to well-being, and it could turn out to be more convenient to measure health by those other properties or consequences than by measuring well-being. But given the enormous heterogeneity among health states, it would seem to be most direct and natural to measure health or to assign values to health states by measuring their contribution to well-being. Taking the measure of health to be a measure of well-being may seem like an obvious step to make. How else could one make sense of the claim that someone who is deaf is in better health than someone with severe angina? But it is a fateful step as well, because it implies that if those who have a disability such as deafness are not thereby worse off than those who can hear, then either they are not in fact disabled after all or disability is not a form of diminished health. I shall return to this conundrum later.

Most attempts to quantify overall health purport to measure “health-related quality of life” [see Kind (1996), Kaplan et al. (1998, p. 509), and http://www.fhs.mcmaster.ca/hug/]. But it is hard to know what to make of this statement, because most of the health-measurement literature leaves the meaning of “health-related quality of life” completely obscure. Bogner and Hirose are an exception. They describe health-related quality of life as “that fraction of overall well-being that is determined by health” (2014, p. 31). In practice, health economists measure health-related quality of life by eliciting preferences. If one believes that preference satisfaction constitutes well-being or, more reasonably, that the extent to which preferences are satisfied constitutes good evidence concerning well-being, then it appears that health economists are taking the value of health states to consist in the contribution that health makes to well-being.

2. Is Health an Evaluative or a Naturalistic Concept?

There is a heated literature devoted to the question in the section heading, which I shall not attempt to survey. (See also Chapter 1 of this book.) There is one influential naturalistic view, which identifies human health with the efficiency with which the parts and processes of the body are functioning, where (very roughly) efficiency is a matter of the extent to which the parts and processes contribute to the survival and reproduction of the person (Boorse 1977, 1997). On the evaluative side, one finds many different views, which agree that in order for a physical or mental state to constitute a pathology, it must have some evaluative feature such as making people worse off, diminishing their opportunities, calling for medical treatment, excusing behavior that would ordinarily be condemned, or calling for sympathy and care from others (Cooper 2002, Engelhardt 1974, Fulford 1989, Nordenfelt 2000, Reznek 1987, Venkatapuram 2011, Wakefield 1992). Both sides agree that health contributes to well-being both causally and constitutively. The issue is whether this contribution to well-being defines, in part, what constitutes health.

Although the naturalistic view faces detailed criticisms (Hausman 2012a, Kingma 2007, 2010, Schwarz 2007), I think that two of the arguments against evaluative views of health are decisive. And if health is not an evaluative notion, it cannot be identical to a state of well-being. First, evaluative views face counterexamples. Some states of health, such as a malfunction in just one kidney, diminish health without diminishing well-being. The bearing of other health states on well-being is sometimes variable. For example, infertility in premenopausal women constitutes a health problem. This health problem sometimes diminishes well-being, but it sometimes enhances it. To maintain that infertility is a health problem only when it is unwanted squarely contradicts the usage of pathologists, and it would permit us to
cure health problems by convincing people to be happy with their physical or mental states or by changing social values. Another response to counterexamples like infertility might be to maintain that it is a conceptual truth that greater health typically goes with greater well-being, not that it always does. That is an odd conceptual truth, and it’s not obvious that it matters whether anything rides on whether one grants it or denies it.

The second, and to my mind more decisive, reason to reject an evaluative notion of health is that the contribution that a given health state makes to well-being and to other values depends on the geographical, technological, and cultural environment and on the objectives and values of individuals, whereas the state of someone’s health is largely independent of these other factors. Two people who are both deaf and whose physical and mental health is otherwise the same are in the same state of health. But the contribution that their health makes to their well-being depends on the accommodations that their societies provide, the risks in their respective environments, the attitudes of the communities in which they live, their activities and objectives, and so forth. Nor can one separate the differences in their well-being into a common health-related component and a differing non-health-related component. As John Broome argues (2002), the contribution that health makes to well-being interacts with the contribution of other things. One cannot add them up. Maintaining a sharp distinction between the health of these two deaf individuals and their health-related well-being is crucial if one wishes to describe their situations sensibly.

So one should reject the view that health is defined, at least in part, by its value, whether that value lies in its contribution to well-being or in some other evaluative aspect. To the extent that the view that health is a species of well-being rests on the conceptual claim, one has reason to deny that view as well. Of course, health typically has great value, but that value depends on facts about people and their environments that are separate from health. Health is a matter of how adequately the parts and processes in the body and mind are carrying out their functions.

3. Measuring and Valuing Health by Well-Being

Even though health is not defined by well-being, it may be that what matters about health for practical purposes is its contribution to well-being, and there are apparently powerful arguments in defense of valuing health by its impact on well-being. I shall consider three of these arguments. The first points out simply that there are practical methods for measuring well-being by means of measuring preferences or by means of measuring subjective experience. These methods are imperfect, but at least they exist. Their feasibility is not in question. What feasible alternative is there?

The second argument for valuing health by its contribution to well-being may be formulated as follows:

1. Subject to the constraints imposed by other moral considerations, such as fairness or respect for individual rights, health policy should aim to minimize the loss of well-being due to ill health.
2. To minimize the loss of well-being due to ill health (subject to appropriate constraints), those who make health policy need to know the impact of ill health on well-being.
3. Those who make health policy need to know the impact of ill health on well-being.

This argument is rarely stated explicitly, but it is nevertheless important. Its first premise—that social policy, including health policy, should aim to promote well-being—is however contestable, and as I shall suggest following in section 4, there is good reason why health policy should
have other aims. Moreover, the argument does not establish that other information is not also of value to those making health policy.

The third argument appears, at first glance, to provide even stronger support for valuing health by well-being. The argument is implicit in the following passage from Bognar and Hirose (2014, p. 30):

> For, ultimately, we do not much care about health itself. What we do care about is its value for us: the way it affects our well-being or quality of life. . . . Consequently, when we allocate health care resources, we should be interested in their impact on quality of life. In other words, what matters is the impact of health on well-being.

In much the same spirit, Broome (2002, p. 94) maintains that health states should be evaluated so as "to measure how good a person's health is for the person, or how bad her ill-health. . . . That is to say, it aims to measure the contribution of health to well-being." The argument that is implicit in these quotations can be stated as follows:

1. The value of a health condition for an individual in that condition is the same thing as how good the health condition is for that individual.
2. How good something is for an individual is the extent to which it promotes or diminishes that individual's well-being.
3. Thus, the value of a health condition for an individual in that condition is the extent to which it promotes or diminishes that individual's well-being.

This argument is shot through with ambiguities and possible equivocations. It might seem that nothing could be more obvious than that the value of something for an individual is how good it is for the individual. But the value of something for me may lie in its promoting things that I care about that have nothing to do with my well-being. Those things that make states of affairs good or bad for people need not increase or decrease their well-being. Losing my hearing might be bad for me because of its effect on how well my life goes or because it prevents me from promoting other objectives that I care about. The range of things that affect the choiceworthiness of alternatives is wider than the range of things that affect someone's well-being, and the ranking (and consequently the measure) of alternatives in terms of choiceworthiness is not the same as the ranking or measure of alternatives in terms of well-being (Scanlon 1998, chapter 3).

4. Against Valuing Health by Its Contribution to Well-Being

The most important objections to identifying the values of health states with their contributions to well-being are at the same time critiques of the three arguments in favor of doing so. First, well-being is hard to measure, and the methods of measuring well-being are seriously flawed. So identifying the value of health with its contribution to well-being gives one little empirical grasp of the value of health. Preferences are a good indicator of well-being only under very restrictive conditions (Hausman 2012b), and methods to elicit preferences are faulty. Whether subjective states are good indicators of well-being is controversial, and measurements of subjective states are sensitive to irrelevant features of the measurement context. Second, it is questionable whether the objective of state policy, especially in a liberal state, should be directly to enhance the well-being of the citizenry. The agents of the state do not possess the knowledge or sensitivity to accomplish such a mandate, and it arguably better serves well-being by delegating pursuit of well-being to the individuals themselves and confining state
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policy to providing them with favorable conditions in which to form and pursue worthwhile objectives. On this view, what matters about health from the perspective of liberal social policy is mainly the extent to which it limits what objectives individuals can pursue rather than how much it diminishes well-being.

The third argument against identifying the values of health states with their contributions to well-being derives from the recognition (which is implicit in the critique of the third argument in favor of measuring health by well-being) that people care about many aspects of health in addition to its contribution to well-being. For example, health problems may limit autonomy. Having suffered an injury that limits my physical abilities to take care of myself, I may be forced to limit my activities to conform to the preferences of my caregivers. Whether these limits make me worse off (i.e., reduce my well-being) is a separate question from whether they limit my ability to govern my own life. Indeed, I may be better off if governed by others. Similarly, a disability such as deafness that need not make me worse off, nevertheless closes off some careers and activities. Health affects freedom, and freedom matters whether or not it has an impact on well-being. That I have more alternatives available to me may make a state of affairs more worthy of choice, but it does not necessarily make my life better. Having more choices, I may make a hash of things.

As this last point implies, identifying the value of health with well-being has seriously mistaken and harmful implications concerning disabilities. As people adapt to a condition such as deafness, their well-being improves more than their physical capacities (Salomon and Murray 2002). Some people are inclined to deny that deafness is a health problem at all, and there is a usage of “healthy” and “sick” according to which we would distinguish among those who are deaf those who are healthy and those who are sick (with the flu, perhaps). But on the view of health as a matter of how well the parts and processes of the body and mind carry out their functions, deafness is a malfunction and a decrement in health. Even those who reject the view of health as functional efficiency ought to concede the point, because otherwise they will find themselves forced to deny that those factors that threaten people’s hearing, such as infections, tumors, or injuries, are threats to health.

Much of the resistance to regarding deafness as a disability (i.e., a form of ill-health) is, I conjecture, a consequence of the mistaken identification of how good someone’s health is with how well his or her life is going. If the measure of health is well-being, then those who are living the best lives must be fully healthy, regardless of whether they can hear. If the measure of health is well-being, then calling deafness a disability is equivalent to asserting that those who are deaf cannot live truly excellent lives, which is of course false. How good the lives of the deaf turn out to be depends on the accommodations that society is willing to make and (like the well-being of individuals who can hear) on the character and good fortune of individuals.

Consider the following statement from the National Association of the Deaf’s position paper on cochlear implants:

Many within the medical profession continue to view deafness essentially as a disability and an abnormality and believe that deaf and hard of hearing individuals need to be “fixed” by cochlear implants. This pathological view must be challenged and corrected by greater exposure to and interaction with well-adjusted and successful deaf and hard of hearing individuals.

(National Association for the Deaf 2000)

This quotation assumes that calling deafness a disability implies that the deaf are not “well-adjusted and successful.” If it follows from granting that deafness is a disability that the lives of the deaf are inferior to the lives of those who can hear, then representatives of the deaf
community should of course deny that deafness is a disability. Given the mistaken identifica-
tion of disability with diminished well-being, that denial is entirely justified.

Instead of denying that deafness is a disability, one should deny that disability necessarily
diminishes well-being. One should understand the claim that deafness is a significant disability as
asserting only that it involves a dysfunction in the auditory system and that this dysfunction
has significant consequences. These claims are platitudes and do not challenge the value of
the lives of those who are deaf. Not being able to hear increases the risks of injury, and it limits
the projects people can pursue and which enjoyments they can have. Some central features
of human cultures are inaccessible to the deaf. For these reasons, deafness is a significant dis-
ability, but the fact that the range of activities and enjoyments is narrower does not imply that
activities and enjoyments within that range are in any way inferior. The fact that deafness is
in this sense a disability is consistent with the possibility that the lives of the deaf are every bit
as rich and fulfilling as the lives of those with good hearing. Well-being is not a good measure
of the value of health.

5. Health Is Not a Kind of Well-Being

As I said at the beginning, this chapter denies both that the value of health is its contribu-
tion to well-being and that health is a kind of well-being. In fact, health differs in significant
ways from well-being. These differences cast doubt on the prospects of measuring health by its
impact on well-being, and they suggest that it should be easier to assess people’s health than to
measure their well-being or to measure the contribution of health to their well-being.

The first difference between well-being and health and its value is that among people of the
same sex and roughly the same age there is comparatively little variation in what counts as
good health, while utterly different lives may be good lives and good, in part, because of their
differences rather than despite them. To exaggerate the point, one might say that there is one
way to be healthy, while there are many ways to have a good life. The good life for some people
consists in taking risks, whereas others thrive in quiet comfort. Some people flourish by pursu-
ing their ambitions, but others focus on friends and family. Good lives are almost as diverse as
people’s objectives, but good health is much the same for everyone.

A second contrast helps to explain the first. One reason why well-being is diverse, while
good health is uniform, is that what is good for me depends heavily on my goals and values,
while my self-definition is less relevant to how good my health is. This is why the dimin-
ished health of someone who is deaf does not imply diminished well-being. By valuing
those aspects of life to which deafness is irrelevant, there is no limit to how good the life of
someone who is deaf can be. This contrast requires some qualifications. The value of health
often depends on the technological, geographical, and cultural environment, but within any
given environment, the value of health for the most part varies little from one individual to
the next. Well-being, on the other hand, depends heavily on individual values and goals. If,
as Joseph Raz (1986), T. M. Scanlon (1998), and others argue, succeeding in the pursuit of
one’s own worthwhile goals is central to well-being, then one would expect that the details
of good lives will be diverse.

A third difference between well-being and health is that interpersonal comparisons of well-
being pose serious problems, while interpersonal health comparisons are not substantially more
difficult than intrapersonal comparisons. When talking about how healthy someone is, it is
largely irrelevant who the somebody is. Comparisons of which of two people is in better health,
like comparisons of whether a person at one time is in better health than that same person at
another time, are comparisons of the health conditions. The features of the person who experi-
ences those health conditions are typically of little importance.
On the other hand, when one is concerned with well-being or how health states bear on well-being, the standards of comparison vary widely across people. Unlike the activities of a single individual, whose values can often be compared with respect to the individual’s unchanged aims, and unlike the mental states of an individual, which are experienced by a single subject, it is unclear how to compare the contributions to well-being of the activities of separate individuals and how to compare the quality of their mental states. For policy purposes, it may be convenient to suppose that people in similar circumstances are equally well-off, but this supposition is at best an extremely rough simplification. In the same circumstances, including the same health state, one person may be thriving, while another is miserable. It is very hard to specify a method for making interpersonal comparisons of well-being that is not subject to serious ethical criticisms (Hausman 1995).

A fourth contrast concerns the objects of appraisal. In assessing the well-being of individuals who are deaf (like the well-being of individuals who can hear), we think primarily of their whole lives, and our appraisal of how well their lives are going during a limited period often depends on what their lives are like before or after that period. On the other hand, when considering people’s health, we think mainly about how healthy someone is during some period. Our appraisal of someone’s health during a period does not depend on comparing it to health in previous or succeeding periods or on placing it within the narrative of a whole life.

The temporal separability of health does not rule out an evaluation of lifetime health, and the temporal inseparability of well-being does not prevent one from judging people’s well-being during one period or another. The difference is that the lifetime health appraisal is less informative than the time-limited appraisals it summarizes, whereas an evaluation of how well whole lives have gone is more informative than judgments concerning their well-being during various periods. How good a life is cannot be determined by adding up or averaging how good it is during separate periods (Griffin 1986, pp. 34–35), whereas how healthy someone’s life as a whole has been is precisely such a sum or average. The trajectory and narrative of a life are crucial elements of well-being, but they are irrelevant to the appraisal of health.

These four contrasts between well-being and health do not imply that health cannot be valued by its bearing on well-being, but they undermine the motivation for attempting to value health this way. What counts pretheoretically as good health (or as better health) is reasonably uniform, interpersonally comparable, largely independent of individual aims and values, and concerned mainly with limited periods within people’s lives. Why, then, attempt to value health in terms of something that is diverse and hard to compare across individuals, that depends on individual aims and values, and that is mainly concerned with whole lives?

6. Conclusions

Health is not a species of well-being, and it is not defined by well-being. Unless well-being is defined as consisting of everything that matters to individuals, what matters about health and constitutes its value is not only its contribution to well-being. As the example of deafness illustrates, substantial dysfunctions that limit what people can do, what they can enjoy, and what risks in their environments they can respond to need not lessen well-being. Measures of health in terms of well-being are unreliable, and these measures lead to deep confusions concerning the concept of a disability and to needless offense to those who experience disabilities.

In discussing the relations between the value of health and well-being, I inevitably made a number of remarks about the measurement of health, and implicit in this chapter is an argument that health ought not to be measured by its contribution to well-being. Before drawing that conclusion, however, one needs to consider whether there is any better alternative than measuring health by well-being. That is, however, a question for another occasion. Regardless
of how that question is answered, health is not a species of well-being. Although both a cause and a constituent of well-being, its value cannot be measured by its contribution to well-being.

References


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Further Reading


